MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Hospice 02-03

Issued: March 1, 2002

Subject: Uniform Billing

Effective: Upon Receipt

Programs Affected: Medicaid, Children's Special Health Care Services (CSHCS)

Please incorporate this important information regarding successful transition to the UB-92 billing format.

Pen and Ink Change

Page 3 of Michigan Department of Community Health (MDCH) Bulletin "Hospice 02-01" issued January 1, 2002 contains an error in billing instructions for physician services. Please make a pen and ink change to your bulletin. The correct billing instructions are as follows:

> Revenue Code 657 "Physician Services" requires a HCPCS code be included on the claim line. Each physician service must be billed on a separate claim line.

Revised Hospice Membership Notice

The former Hospice Membership Notice (used for enrollment and disenrollment) has been revised to accept specific nursing facility information for hospice beneficiaries who reside in or are admitted to a nursing facility for routine hospice care. The new form number is DCH-1074**(E)** for fill-in enabled completion, and DCH-1074 for typewritten completion. This replaces and obsoletes the previous editions (MSA-4443 and DSS-4443). **Please discard all obsolete editions of the Hospice Membership Notice.**

Because the form is not currently available on the MDCH website, a camera-ready copy of this form is included with this bulletin. Please photocopy this form. It is recommended that you reserve this copy as the original so print quality remains stable. It is anticipated that the form will be on the MDCH website by the end of March 2002. Specific directions for downloading the form will be available on the website. The website address is www.mdch.state.mi.us.

When the form is available on the MDCH website, it will be fill-in-enabled [DCH-1074(**E**)] or camera-ready [DCH-1074] for photocopying. Fill-in enabled allows copying of the form to a computer file. The user then has the ability to complete the form on a personal computer,

except for the required beneficiary signature. Although at this time the MDCH is not able to electronically process hospice enrollment, disenrollments, or enrollment updates, this is the first step in providing that capability. For current ease of enrollment, the hospice may **fax** the form to (517) 373-1437. Providers no longer are required to submit the form through US Mail.

The addition of the specific nursing home information for hospice beneficiaries who reside in or are admitted to a nursing home changed the order of the numbered boxes in the previous form. Please use the directions below. A bulletin with updated manual pages will be issued in the future.

COMPLETION INSTRUCTIONS FOR THE HOSPICE MEMBERSHIP NOTICE

The Hospice Membership Notice, DCH-1074(**E**) and DCH-1074, is used as an enrollment application, enrollment update, and disenrollment notice. The hospice indicates which function the form is serving by checking the appropriate box at the top right hand side of the form and including an effective date. The enrollment update function is to inform the MDCH that a hospice beneficiary has moved from their home to a nursing facility for their routine hospice care. This information is critical to payment of room and board for those hospice beneficiaries.

The entries on the form must be typed. The beneficiary information must be taken directly from the Medicaid ID Card or the Department's computerized eligibility information system. If the beneficiary information is incorrect on the Medicaid ID Card, advise the beneficiary to contact his/her local Family Independence Agency worker to correct the information.

A copy of the enrollment application must be given to the beneficiary, and the original must remain in the beneficiary's file. If the beneficiary elects to disenroll from the hospice, the hospice must give a copy of the disenrollment notice to the beneficiary when he/she signs it, and retain another copy in the beneficiary's file. If the beneficiary is disenrolled for any other reason (e.g., his/her prognosis changes, negating the need for hospice services), the hospice must mail a copy of the disenrollment notice to the beneficiary with a letter, explaining the reason and effective date of disenrollment. **Elective disenrollments must be signed and dated**.

HOSPICE MEMBERSHIP NOTICE AS AN ENROLLMENT APPLICATION

The hospice must complete the Hospice Membership Notice as an enrollment application according to the instructions below. The hospice must read the conditions of enrollment on the form to the beneficiary, and answer any questions raised.

PROVIDER INFORMATION

Item 1: The **effective date of enrollment** is a mutually agreed upon date by the hospice and the beneficiary. If the beneficiary is currently in a hospital, the effective date of hospice enrollment must be after the effective date of hospital discharge.

Item 2: **The Enrollment Update box** is checked to indicate that the beneficiary has been admitted from their home to a nursing facility for their routine hospice care. By checking this box and providing the required nursing facility information in items 15 thru 18, the hospice can receive payment for nursing facility room and board for the beneficiary.

Items 3 and 4: For enrollment, these items remain blank.

Item 5: The name of the hospice **(provider name)** must be entered. The hospice may use the abbreviation that is recognized by the Provider Enrollment section of the MDCH.

Item 6: The hospice's Medical Assistance **provider identification number** must be entered exactly as it appears on the hospice's Provider Enrollment Turn-Around form.

Item 7: This **control number** item is for hospice use only.

Items 8 and 9: The **attending physician's** name and his/her address must be entered.

Items 10 and 11: The **area code and telephone number** for the hospice. The **area code and FAX number** for the hospice.

Items 12 and 13: Enter the attending physician's **Medicaid provider identification number** and **provider type**.

Item 14: Indicate whether the beneficiary is receiving services from the **MI-Choice waiver program** in addition to services from the hospice.

NURSING FACILITY INFORMATION

Items 15 thru 18: The **name of the nursing facility** that the beneficiary resides in (if applicable) or has been admitted to for routine hospice care. The Medicaid nursing facility provider identification number, nursing facility address, and the **date the beneficiary was admitted to the nursing facility.**

BENEFICIARY INFORMATION

Items 19 thru 21: The beneficiary's **name, address** and **complete Medicaid identification number** must be entered as they appear on the Medicaid ID Card.

Item 22: The beneficiary's **nine-digit social security number** must be entered. Do not use hyphens in the social security number.

Item 23: The beneficiary's **date of birth** with 4-digit birth year must be entered

Item 24: The beneficiary's **gender** must be appropriately indicated.

Item 25: The beneficiary's home **telephone number, including area code**, must be entered, if applicable.

Item 26: If the beneficiary is NOT enrolled in the **Children's Special Health Care Services**, an "X" must be placed in the NO area.

If the beneficiary is enrolled in the **Children's Special Health Care Services**, an "X" must be placed in the YES area.

Item 27: The **beneficiary's previous level of care** (from the Medicaid ID card, or the Department's computerized eligibility system) must be indicated here.

Item 28: Indicate whether the beneficiary previously received hospice services.

Item 29: The **beneficiary's estimated remaining life span** (in months) must be entered here.

Item 30: If appropriate, the name of the beneficiary's **legal parent or guardian**, who is authorizing hospice enrollment by signing Item 39 on the form, must be entered

Item 31: The **beneficiary's terminal diagnosis** must be entered using the appropriate **alphanumeric diagnosis code(s).** Common terminology cannot be substituted for the diagnosis code. Diagnosis codes are listed in the International Classification of Diseases - 10th Revision - Clinical Modification (ICD-10-CM). The enrollment cannot be processed without the appropriate alphanumeric ICD-10-CM code. **A primary diagnosis code is required for hospice enrollment.** If available, the hospice may enter the secondary and tertiary codes applicable to the hospice admission.

OTHER HEALTH INSURANCE

Items 32 thru 37: The hospice must enter any **resources** the beneficiary has other than Medicaid. The information may be found on the beneficiary's Medicaid ID Card. The hospice must ask the beneficiary if he/she has **other health insurance.** If the beneficiary has other insurance, but it is not indicated on the Medicaid ID Card, the hospice should advise the beneficiary to contact his/her local Family Independence Agency worker to correct the information. The hospice may notify the worker of the beneficiary's other insurance coverage also.

REMARKS

Item 38: Enter information in the REMARKS section only when specifically directed to do so.

FOR ENROLLMENT ONLY

Providers are reminded that if the beneficiary resides in a nursing facility**, the hospice must include the name, address, and Medicaid provider identification number of the nursing facility in item numbers 15 thru 18 of the DCH-1074 or DCH-1074(E).** If the beneficiary is admitted to a nursing facility for routine hospice services after submission of the Hospice Membership Notice, **an updated enrollment form must be faxed to MDCH with the nursing facility name, address, and Medicaid provider identification number of the nursing facility. Check Item 2, Enrollment Update, on the enrollment form.** Room and board payments cannot be made **if the nursing facility information is not promptly faxed to MDCH.**

Items 39 and 40: The beneficiary or the beneficiary's representative must sign and date the application. **When a beneficiary's representative, other than the legal parent or guardian, signs the form, that person's name and his/her relationship to the beneficiary must be entered in the REMARKS section. Another person must witness the signature and sign the application in the place provided.** The enrollment form must be received before the first claim is submitted. **Check the beneficiary eligibility system** before submitting the first claim **to verify that the beneficiary is enrolled with hospice level of care 16.**

FOR DISENROLLMENT ONLY

Items 41 and 42: For enrollment, these items remain blank. They are used for disenrollment only.

HOSPICE MEMBERSHIP NOTICE AS A DISENROLLMENT NOTICE

The hospice completes the disenrollment notice according to the following instructions. Only the items listed in the disenrollment instructions must be completed if the hospice uses the previously completed membership notice. If the hospice does not use the previously completed membership

notice, all information contained on that previous document must be entered. The information must be either from that document or according to the COMPLETION INSTRUCTIONS FOR THE HOSPICE MEMBERSHIP NOTICE, as well as following the completion instructions for disenrollment.

- Item 3: The hospice enters the appropriate **disenrollment effective date** as explained in the DISENROLLMENT PROCESS section of the Medicaid Hospice Manual.

- Item 4: The hospice must enter the appropriate code to indicate the **reason** for the disenrollment.

  2 = Deceased

  3 = Beneficiary elected to disenroll

  9 = Other (requires brief explanation in REMARKS; Item 38)

  NOTE: When reason code 9 is used, the reason for disenrollment must be briefly stated in the REMARKS Section (Item 38). Please refer back to the BENEFICIARY ENROLLMENT SECTION of the Medicaid Hospice Manual, "hospice elects to terminate the beneficiary enrollment", for disenrollment examples.

- Items 41 thru 42: The beneficiary or the beneficiary's representative must **sign and date** the disenrollment notice only if the beneficiary or the beneficiary's representative is initiating the disenrollment. When a beneficiary representative (other than the legal parent or guardian) signs the form, that person's name and his/her relationship to the beneficiary must be entered in the REMARKS section. Another person must **witness** the signature and sign the disenrollment notice in the space provided.

Manual Maintenance

Retain this bulletin for future reference.

QUESTIONS

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

APPROVED

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HOSPICE MEMBERSHIP NOTICE

Michigan Department of Community Health

Fax to: (517) 373-1437

☐ **ENROLLMENT APPLICATION** ➔	1. Effective Date		
☐ **ENROLLMENT UPDATE** ➔	2. Effective Date		
☐ **DISENROLLMENT NOTICE** ➔	3. Effective Date	4. Reason Code	

PROVIDER INFORMATION:

5. Provider Name			6. Provider ID Number	7. Control Number
8. Attending Physician Name			10. Hospice Phone Number	11. Hospice FAX Number
9. Physician Address (Number & Street, Suite Number)			12. Physician Provider ID Number	13. Provider Type
City	State	ZIP Code	14. Is this Beneficiary a MI-Choice Waiver Participant? ☐ **YES** ☐ **NO**	

NURSING FACILITY INFORMATION:

15. Nursing Facility Name		16. N.F. Provider ID Number	17. Date Admitted to Nursing Facility
18. Nursing Facility Address (Number & Street)		City	State / ZIP Code

BENEFICIARY INFORMATION:

19. Beneficiary Name (Last, First, Middle Initial)			21. Beneficiary ID Number	
20. Beneficiary Address (Number & Street)			22. Social Security Number	23. Birth Date
City	State	ZIP Code	24. Gender ☐ **Male** ☐ **Female**	25. Home Phone Number
26. CSHCS Beneficiary? ☐ **YES** ☐ **NO**	27. Beneficiary LOC		28. Previous Hospice Enrollee? ☐ **YES** ☐ **NO**	29. Estimated Remaining Life Span Months
30. Legal Parent or Guardian Name (Last, First, Middle Initial)			31. Diagnosis Code(s)	

OTHER HEALTH INSURANCE:

32. Insurance Company Name		33. Policy Holder Name	
34. Policy Number	35. Group or Contract Number	36. Medicare Eligibility *(check one)* ☐ **Part B** ☐ **Parts A & B**	37. Medicare Claim Number

REMARKS:

38.

☐ By placing an "X" or a "✓" in this box, I certify that I have read (or they have been read to me) and understand the Conditions of Enrollment and Certification provisions on Page 2 of this form. Any questions I had about these provisions or my hospice care were answered by a hospice representative.

For ENROLLMENT Only	
39. Beneficiary (or authorized representative) Signature	Date
40. Witness Signature	Date

For DISENROLLMENT Only	
41. Beneficiary (or authorized representative) Signature	Date
42. Witness Signature	Date

AUTHORITY: Title XIX of the Social Security Act **COMPLETION:** Is Voluntary, but is required if Medical Assistance program payment is desired.	The Department of Community Health is an equal opportunity employer, services and programs provider.

CONDITIONS OF ENROLLMENT:

Hospice services are an option of medical care that you may choose while you are in the terminal stages of your illness. Palliative at-home care is the basis for hospice care. If you do not have a family member or friend to care for you in your home, hospice care may be provided while you are a resident of an approved nursing facility (NF), home for the aged, adult foster care facility (AFC) or licensed hospice long term care unit. All Medicaid and any approved Children's Special Health Care Services (CSHCS) covered services for the terminal illness will be provided by the hospice. You must use your Medicaid identification card (ID), health plan card, or CSHCS Eligibility Letter to obtain care from your private physician or health plan for services not related to the terminal illness. You may elect to disenroll from the hospice at any time by signing the disenrollment form.

CERTIFICATION:

By signing this form, I certify that I voluntarily apply for hospice enrollment for myself or the person indicated in item number 19. The enrollment is effective on the date entered on item number 1 and will continue as long as the hospice continues operation and eligibility continues under the Medicaid Program or CSHCS approval. If my Medicaid ID card indicates a patient pay amount, I understand that I must pay that amount, **each month**, to the hospice for my care. Any applicable patient pay amount, insurance payment, and Medicaid reimbursement represents payment-in-full to the hospice. I understand and accept the conditions of enrollment stated above. I authorize any physician or hospital to release medical information to the hospice. I authorize the hospice to release medical information to the Michigan Department of Community Health.